Medical Assistance versus MinnesotaCare side-by-side

Medical Assistance (MA)		MinnesotaCare (MCRE)
Minnesota's Medicaid program that offers public health insurance for individuals and families who meet a certain income level.	**About**	A premium-based program that provides health care coverage for some parents, adults, and children, who are not eligible for MA or Medicare.
To qualify, individuals must meet all program requirements; e.g., residency, household size, age, pregnancy or disability status, immigration status, income, etc. Requirements vary depending on a person's basis of eligibility.	**Eligibility**	To qualify, individuals must meet all program requirements; e.g., residency, household size, age, pregnancy or disability status, immigration status, income, etc. Requirements vary depending on a person's basis of eligibility.
Household income up to 133% of Federal Poverty Guidelines (FPG), or up to 283% for infants up to age 2, up to 275% for children 2 to 18, up to 275% for pregnant women. Uses the most recent month's income as a basis for determining eligibility.	**Income limits**	Household income from 133% and up to 200% FPG, or from 0 to 200% FPG for certain recent immigrants. Uses annual income as a basis for determining eligibility.
No requirement to file a federal income tax return.	**Tax filing status/ requirements**	No requirement to file a federal income tax return.
Must have legal immigration status. Exception: Certain individuals who do not have a legal immigration status may be eligible for Emergency MA.	**Immigration status**	Must have legal immigration status.
ESI is NOT a barrier to MA.	**Employer Sponsored Insurance (ESI)**	Persons with access to ESI that meets Minimum Essential Coverage (MEC) and affordability standards are not eligible for MinnesotaCare.

Medical Assistance (MA)		MinnesotaCare (MCRE)
Managed health care plans, and fee-for-service. Fee-for-service occurs when the provider submits directly to DHS medical claims for the month eligibility begins and any retroactive months.	**Service types**	Managed health care plans and fee-for-service. Fee-for-service occurs when the provider submits directly to DHS medical claims for the month eligibility begins and any retroactive months.
There are no premiums but some enrollees will have co-pays.	**Premiums and co-pays**	Most enrollees pay premiums and have co-pays.
When an eligible consumer chooses a health plan based on plans available in their county of residence or a default plan is assigned by the system. This occurs the month after they are determined eligible for MA.	**Managed health care enrollment occurs**	An eligible consumer chooses a managed health care plan based on plans available in their county of residence or a default plan is assigned by the system. Services are covered by the managed health care plan on the day coverage begins.
Yes, if qualifications are met.	**Retroactive coverage**	No
Yes, if qualifications are met.	**Emergency coverage**	No
If eligible, coverage typically begins the first of the month of application, but it may begin up to the first day of the month three months before the month of application, if the consumer has requested retroactive coverage. Medical claims for the month eligibility begins and any retroactive months are submitted by the provider directly to DHS, which is called fee-for-service.	**Coverage begins**	Coverage begins on the first day of the month following the month the premium payment is received, or following the month a determination of eligibility is made (if premium payment is not required).
Eligibility and coverage end at the end of the month following a 10-day advance notice.	**Coverage ends**	Coverage ends at the end of the month following a 10-day advance notice of closure.
Renewal is one calendar year from the anniversary of their application date.	**Renewal**	Renews on January 1, regardless of enrollment date.